Study characteristics							Patients' characteristics at baseline								Informal caregivers' (CG) characteristics at baseline					Needs assessment			Needs complexity		Intervention characteristics (structure and process quality criteria)																								Outcomes		Results for each outcome	Results for outcomes related to informal CG	Comments
Author, Journal, Year	Title	Type of study / Design	Aim of study	Inclusion criteria	Centre (single - multicentric)	Country	Level of Evidence e +/-LoE (SIGN) / Justification	Number of patients / Dropouts / (DO) / Dropouts through death (DOd)	Female / Male (n/n)	Age (mean, SD)	% of patients with cancer	1. Diagnosis 2. stage/grade 3. phase of illness	Performance status (ECOG, ...)	Patients' needs (psychosocial, spiritual, etc...)	Others	Number of CG / Drop outs	Female / Male (n/n)	Age (mean, SD)	CGs'needs (psychosocial, spiritual, etc...	Others	Who assesses	When	How (tool)	Categories	Process of categorisation (needs > complexity)	Overall description	Setting	Health care providers: Total, n/profession or qualification	Number of places/ beds	Equipment (incl. drugs, EOV, setting/ room/ housing)	Funding		Organisation / Management related to structures		Referral criteria / allocation of place	Description of intervention		Description of bereavement intervention		Description of control intervention	Coodination of intervention		Discharge criteria	Integration of oncological and palliative structures		Others	Primary outcomes (1.O) : Secondary outcomes (2.O) / Measure (tool, when, how long)	Costs			
																									Intervention	Control				Who (source)	How much	Who	How		Schedule/Frequency	Content (clinical/non-clinical)	Schedule/Frequency	Content		Who	How		Who	How					
SEKTORENÜBERGREIFENDE SPV-STUDIEN (Hiermit werden Studien verstanden, die SPV-Interventionen untersuchen, deren Setting strukturübergreifend ist. Das sind Interventionen, die mindestens zwei SPV-Versorgungsstrukturen einschließen (Palliativstation, Home-Care-Programme, etc...) und diese in den Ergebnissen nicht unterschieden.																																																					
Dunt, Palliative Medicine, 1999 [177]	The cost-effectiveness of the citymission Hospice Porgramme Melbourne	quasi-experiment al	to examine costeffectiveness, according to costs and clinical benefit, of hospice care in comparison to standard care.	known histologically confirmed diagnosis of cancer and terminal phase (less than six months)	single center	Australia	2-	n = 120 (55 intervention, 55 control) creating 271 patient and 195 caregiver interviews	intervention: 33/32, control: 28/29	less than 60 (interv. 21 and control 16 ; age not otherwise specified		100%	Intervention: Lung (n=14), Breast (n=6), colorectum (n=11), Other (n=32) control lung (n=7), Breast (n=9), colorectum (n=11), others (n=33)	KarnofsKy Performance Status(n=82) intervention: n = 25; control: n= 9	Intervention/control: usual pain: pain severity(n=412), pain duration (n=19/30), pain frequency (n=15/23), worst pain severity (n=29/34), duration of shortness of breath (n=4/8), insomnia (n=5/9), weakness (n=23/22), bowel complaints (n=10/4), Nausea/vomiting (n=7/6), loss of symptom (n=37/33), anxiety (n=11/16), depression (n=16/15); dissatisfaction with caare score (n=5.5/4.5), QL index (n=3.5/4.0), perceived dependency (n=11/15), pleasure stife (n=18/20), social contacts (n=14/16)		intervention:611 control:53	not mentioned	not mentioned	not mentioned	anxiety (n=17/11), depression (n=5/3), fatigue (n=7/5), difficulty in CG into daily activities with patient's care score (7.0/7.3)	none	trained interviewers	1monthy after baseline until death	Levels of symptoms and other outcome variables: 3 point VRS (none, mild, moreate, severe, every severe), measurement of QL index, Tunstall's social contact score, functional dependency: KPS	not specified	not specified	hospice programme (CMP = Citymission Hospice Programme)	conventional care	inpatients and outpatients (home care programme)	Medical care was provided jointly by two RMH oncologists (on a part-time basis), both with a special interest in palliative care, as well as three registrar-level medical staff undertaking training with one oncologist and also with special interest in palliative care (Medical establishment - 1.0 full-time equivalents approx.) The remainder of the CHP staff consists of 1 clinical coordinator, secretary, inpatient and home-care nurses, chaplain, coordinator of volunteers, sessional pharmacist, other patientcontact staff and a corps of volunteers.	10-bed inpatient facility, with a 50 bed nursing home for the frail aged. It also provides a home care programme, catering up to 100 patients with an on-call afterhours system ensuring a 24-hour, seven-day cover.	not specified	The Citymission Hospice Programme was funded as a joint initiative of the WK Kellogg Foundation, the Australian Federal Government and several Australian philanthropic trusts.	not specified	not specified	not specified	clinical judgement and geographical area	not specified	all the services usually associated with hospice care, including thorough-going symptom relief, emotional support, whole-patient care and, where appropriate, whole-family care either in the patient's home or in a home-like institution	not specified		Standard care: Medical care of these patients was provided variously by oncologists, general specialists or GPs.	not specified	not specified			Thus while symptom control, with the emphasis on emotional or social support, is generally very much the programme some aspects of the patient's previous care continue, e.g. chemotherapy, hospital inpatient care, general practitioner medical care in the home.		physical and emotional symptoms of patients: 1st assessment: control had higher visual pain duration (OR 2.5: CL 1, 5.6-6.4); No other sign. Results last assessment: control had higher levels of usual pain severity (OR 9.9: CL 2.1-45.5), worst pain severity (OR 5.0: CL 1.0-24.5), shortness of breath (OR 11.9: CL 1.1-131.0), insomnia (OR 5.7: CL 1.1-31.2) **emotional difficulties of the caregiver** last assessment control caregivers had lower levels of difficulty in their roles as CG (OR:0.3: CL 0.1-0.9)p.for sign results **Satisfaction** The nonhospice group had significantly higher dissatisfaction with care scores **Place of death** % of patients dying at home identical in both groups (42%).	yes		emotional difficulties of the caregiver last assessment control caregivers had lower levels of difficulty in their roles as CG (OR:0.3: CL 0.1-0.9)p.for sign results	methodologically flawed; no definion of intervention, no blinding, relevant differences in baseline results (KPS!) shadowed in results!
Kurie, The Lancet, 1984 (part 1) [178]	A randomized controlled trial of hospice care	RCT, parallel, nonblinded	to compare the effect of hospice care with conventional care	diagnosis of cancer and clinical judgement of terminal prognosis (2 weeks - 6 months)	single center	USA	1-	n=263 (eligible) n= 237 participants n= 10 drop outs after enrolment	231/6	interv. (mean) 65.3 (no SD), control (mean) 64.0 (no SD), range: 34-92		100%	1. Cancer mentioned primary sites: intev.: lung (36,5), prostate (11,0), ENT (8,5), brain (7,3), others (35,6) control : lung (35,5), prostate (10,0), ENT (10,9), brain (7,3), others (36,4) 2. not specified 3. terminal phase according to clinical judgement	not specified	not specified	none	73% of partner had FCG; 59% gave consent; 6% withdew consent	not specified	not specified	not specified	not specified	not specified	regular interviews (7 cohorts = 16 weeks): Methodology outlined separatly in Wales J, Kane RL, Robbins S, Bernstein L, Kroenow R. The UCLA hospice evaluation study: Methodology and instrumentation. Med Care 1983; 27: 734-44.	Pain scores (Mishel: presence or absence of pain; intensity); Symptom Scale adapted from California Pain Assessment Profile; depression scale adapted from the Institute of Mental Health's Center for Epidemiologic Studies' scale; anxiety derived from General Well-Being Questionnaire; satisfaction (interpersonal care scale adapted from the Ware scale, physical environment scale based on McCaffee and Harkins); bereavement-in-care questions adapted from Nat. Cancer Institute's Hospice Study); functional status (Katz Activities of Daily Living scale)	not specified	not specified	hospice care	conventional care	inpatients, hospice home care	2 physicians, 19 nurses, a social worker, a chaplain, and about 30 volunteers for 11 beds; a homecare programme serving about 25 patients at any given time; a consultation service for patients awaiting admission	11 beds, about 25 home care patients	not specified	VA Medical Center	not specified	not specified	not specified	clinical judgement of terminal prognosis	hospice care due to hospice program assessment and its own treatment plan	not specified	none	none	conventional care	hospice team	by routine practice	none	none	none	none	differences in pain, symptoms, activities of daily living (functional status) and affects (satisfaction (patients), satisfaction (carers)), utilisation of services (hospitalisation, therapeutic procedures,...) costs	yes		differences in pain, symptoms, activities of daily living (functional status) and affects (satisfaction (patients), satisfaction (carers)), utilisation of services (hospitalisation, therapeutic procedures,...) costs	satisfaction equally improved	unescarnably bias due to gender, intervention not clearly defined;
Kane, JAMA 1985 (part 2) [179]	Hospice Effectiveness in controlling pain	RCT, parallel, nonblinded	to compare the effect of hospice care with conventional care on pain	diagnosis of cancer and clinical judgement of terminal prognosis (2 weeks - 6 months)	single center	USA	1-	n=263 (eligible) n= 237 participants n= 10 drop outs after enrolment	231/6	interv. (mean) 65.3 (no SD), control (mean) 64.0 (no SD), range: 34-93		100%	2. Cancer mentioned primary sites: intev.: lung (36,5), prostate (11,0), ENT (8,5), brain (7,3), others (35,6) control : lung (35,5), prostate (10,0), ENT (10,9), brain (7,3), others (36,4) 2. not specified 3. terminal phase according to clinical judgement	not specified	not specified	none	none	not specified	not specified	not specified	not specified	referral to methodology being publishing elsewhere:Wales J, Kane RL, Robbins S, Bernstein L, Kroenow R. The UCLA hospice evaluation study: Methodology and instrumentation. Med Care 1983; 27: 734-44.	loss Pain scores according to Mishel	not specified	not specified	hospice care	conventional care	inpatients, hospice home care	not specified	11 beds, 30 home care patients	not specified	VA Medical Center	not specified	not specified	not specified	clinical judgement of terminal prognosis	hospice care due to hospice program assessment and its own treatment plan	not specified	none	none	conventional care	hospice team	by routine practice	none	none	none	none	differences in pain scores, correlation with other symptoms use of analgecs	no		no sign effects	none	intervention not clearly defined; exactly the same study and the same results reported as in Lancet 1984
Kane, J. Chron Dis, 1986 [180]	The role of hospice in reducing the impact of bereavement	RCT, parallel, nonblinded	to compare the effect of hospice care with conventional care	diagnosis of cancer and clinical judgement of terminal prognosis (2 weeks - 6 months)	single center	USA	1-	n=263 (eligible) n= 237 participants n= 10 drop outs after enrolment	231/6	interv. (mean) 65.3 (no SD), control (mean) 64.0 (no SD), range: 34-92		100%	1. Cancer mentioned primary sites: intev.: lung (36,5), prostate (11,0), ENT (10,9), brain (7,3), others (36,4) 2. not specified 3. terminal phase according to clinical judgement	not specified	not specified	none	n = 162 (83 inv + hospice, 69 controls + regular care)	52 female in intervention / 56 in control	68 (SD 12) years in interv, 66 (14) in control	anxiety, depression bereavement.	26 chronic health problems (list)	not specified	additional interviews 6weeks, 6, 12 an 18 months after death	anxiety measure, Rand Health Insurance Study, depression: CES-D Scale, sequelae of bereavement, participation in social activities and social contacts, smoking habits and alcohol consumption, use of medication, bed-disability days, work days lost, restricted activity days, hospitilisation, physician visits, self assessment of health scale	not specified	not specified	hospice care	conventional care	inpatients, hospice home care	not specified	11 beds	not specified	VA Medical Center	not specified	not specified	not specified	clinical judgement of terminal prognosis	hospice care due to hospice program assessment and its own treatment plan	not specified	none	none	conventional care	hospice team	by routine practice	none	none	none	none	differences in anxiety scale, CES-D Depression Scale, health scale score and items of the sequelae bereavement list	no	no sign effects between the two groups	no sign effects	intervention not clearly defined; exactly the same study and the same results reportes as in Lancet 1984 remains vague
Wales, J. Medical Care, 1983 [181]	UCLA Hospice Evaluation Study	RCT	to establish robust methodology		single center	USA	1-																																																to mat figures given, re-test reliabilities based on assumptions (24hours), the gaps in applied methodology of the main studies are not explained by this article despite it being mentioned as the relevant methodology elsewhere
Zimmermann C, Lancet, 2014 [182]	Early palliative care for patients with advanced cancer:a cluster-randomised controlled trial	Cluster-Randomised Controlled Trial	To evaluate if, compared with standard cancer care, early intervention clinical prognosis of 6–24 months) by a palliative care team would be associated with improvement quality of life, symptom control, and satisfaction with care, and less difficulty with clinician-patient interactions.	Age > 18 years, stage IV cancer, breast or prostate cancer refractory to hormonal therapy, patients with stage III cancer and poor clinical prognosis were included at the discretion of the oncologist (assessed by estimated survival of 6–24 months (assessed by their main oncologist); and ECOG-performance status ≤ 2 (rated by their main oncologist).	24 clinics (clinics) randomised: 12 clinics allocated to control group and 12 clinics allocated to intervention group (12 clusters) NO=24 NO=17 n=228 (intervention) NO=12, NO=15	Canada	1++	24 Clusters (clinics) randomised: 12 clinics allocated to control group and 12 clinics allocated to intervention group (12 clusters) NO=24 NO=17 n=228 (intervention) NO=12, NO=15	intervention: 130/52, control: 125/108	intervention: 61,2 (SD 12,3) Control: 60,2 (SD 11,3)		100%	Cancer: 1. stage IV 2. stage III cancer and poor clinical prognosis were included at the discretion of the oncologist (assessed by survival 6-24 month	ECOG= 0, 1 or 2 (assessed by the patients main oncologist) Intervention ECOG=0: 91 (56,8%) ECOG=1 149 (65,4%) ECOG=2 18 (7,9%) Control: ECOG=0 76 (32,6%) ECOG=1 143 (61,4%) ECOG= 2 14 (6,0%)	Intervention: FACIT-Sp (n=440) 101 (SD 20,3) QUAL-E (n=436) 73 (SD 11,1) ESAS (n=461) 28 (15,5) FAMCARE-P16 (n=449) 64 (9,7) CARES-MIS (n=448) 4.7 (5,6) Control: FACIT-Sp (n=442) 105 (18,8) QUAL-E (n=436) 74 (11,5) ESAS (n=461) 23 (14,5) FAMCARE-P16 (n=449) 66 (9,7) CARES-MIS (n=448) 3.9 (5,4)				As an exploratory substudy, we also collected data from caregivers; these data will be reported separately			palliative care team. The core intervention was consultation and follow-up in the oncology palliative care clinic by a palliative care physician and nurse	standard cancer care	The Princess Margaret Cancer Centre palliative care service consists of an outpatient oncology palliative care clinic, a 12-bed palliative care unit, and an inpatient consultant team (16 medical oncologists)	a palliative care physician and nurse	outpatient oncology palliative care clinic, a 12-bed palliative care unit, and an inpatient consultant team.	n/a	n/a	n/a a cost analysis is underway, and will establish the economic implications of implementing this model.	n/a	n/a	n/a	n/a		Consultation and follow-up in the oncology palliative care clinic by a palliative care physician and nurse, consisting of: • comprehensive, multidisciplinary assessment of symptoms, psychological distress, social support, and home services, within 1 month of recruitment (60–90 min duration); • routine telephone contact from a palliative care nurse 1 week after the fi rst consultation, and then as clinically indicated; • monthly outpatient palliative care follow-up (20–50 min); and • a 24-h on-call service for telephone management of urgent issues. ▽ Ancillary: Interventions depending on the status of the patient, included: arrangement of home nursing and personal support; GP and hospital palliative care physician (when the patient's ECOG performance status was 3 or worse, or when requested); and admission to the Princess Margaret Cancer Centre palliative care unit for urgent symptom control or terminal care.			no formal intervention, but palliative care referral was not denied, if requested. Participants in the control group referred to the palliative care service received the same care as patients in the intervention group, but did not have the same standardised monthly follow-up.	Princess Margaret Cancer Centre, a comprehensive cancer centre and part of the University Health Network in Toronto, ON, Canada	n/a	n/a	cancer care center with palliative care team			**1.O. :**Change score for FACIT-Sp (Functional Assessment of Chronic Illness Therapy—Spiritual Well-Being; [measures Quality of Life]) at 3 months. **2.O. :**Change score for FACIT-Sp at 4 months. Change scores for other scales at 3 months and 4 months: Quality of Life at the End of Life [QUAL-E] scale, symptom severity: Edmonton Symptom Assessment System [ESAS], satisfaction with care: FAMCARE-P16, and problems with medical interaction: Cancer Rehabilitation Evaluation System Medical Interaction Subscale [CARES-MIS]	ongoing cost analysis that will establish the economic implications of implementing this model.	**1.O. : At 3-months, there was a non-significant difference in** change score for **FACIT-Sp** between intervention and control groups (3.96 points [95% CI -0.27 to 7.40], p=0.07) **2.O. : At 4-month for FACIT-Sp:** differences in change scores were significant (+2.46 [15,47] vs -3.96 [14,21], p=0.006); QUAL-E (+1.54 [8,33] vs -0.51 [7,62], p=0.003), and ESAS (−1.34 [15,98] vs +3.23 [13,60], p=0.05) **At 3-month:** a significant difference in **QUAL-E** (2.25 [0,01 to 4,49], p=0.05) and **FAMCARE-P16** (3.79 [1,14 to 5,85], p=0.005) were also found in favour of **ESAS** (−2.79 [−5,28 to −0,31], p=0.03) or **CARES-MIS** (−0.56 [−2,75 to 0,34], p=0.40).	n/a	Power: initial sample size estimation showed that 390 patients (195 per group) would provide 80% power at the two-sided 5% level of significance to detect a between-group difference in FACIT-Sp of 0•45 SD (medium effect size) by the primary endpoint of 3 months. Intention to treat analysis computer-generated sequence Randomisation: computer-generated sequence Selection bias, which is common in cluster-randomised studies because of randomisation of clusters before consent of individuals. Single-blind; patients knew about the intervention but were not informed about the existence of another group. Results of the single clinics not reported separately. Unclear what "early" means - no definition is reported.